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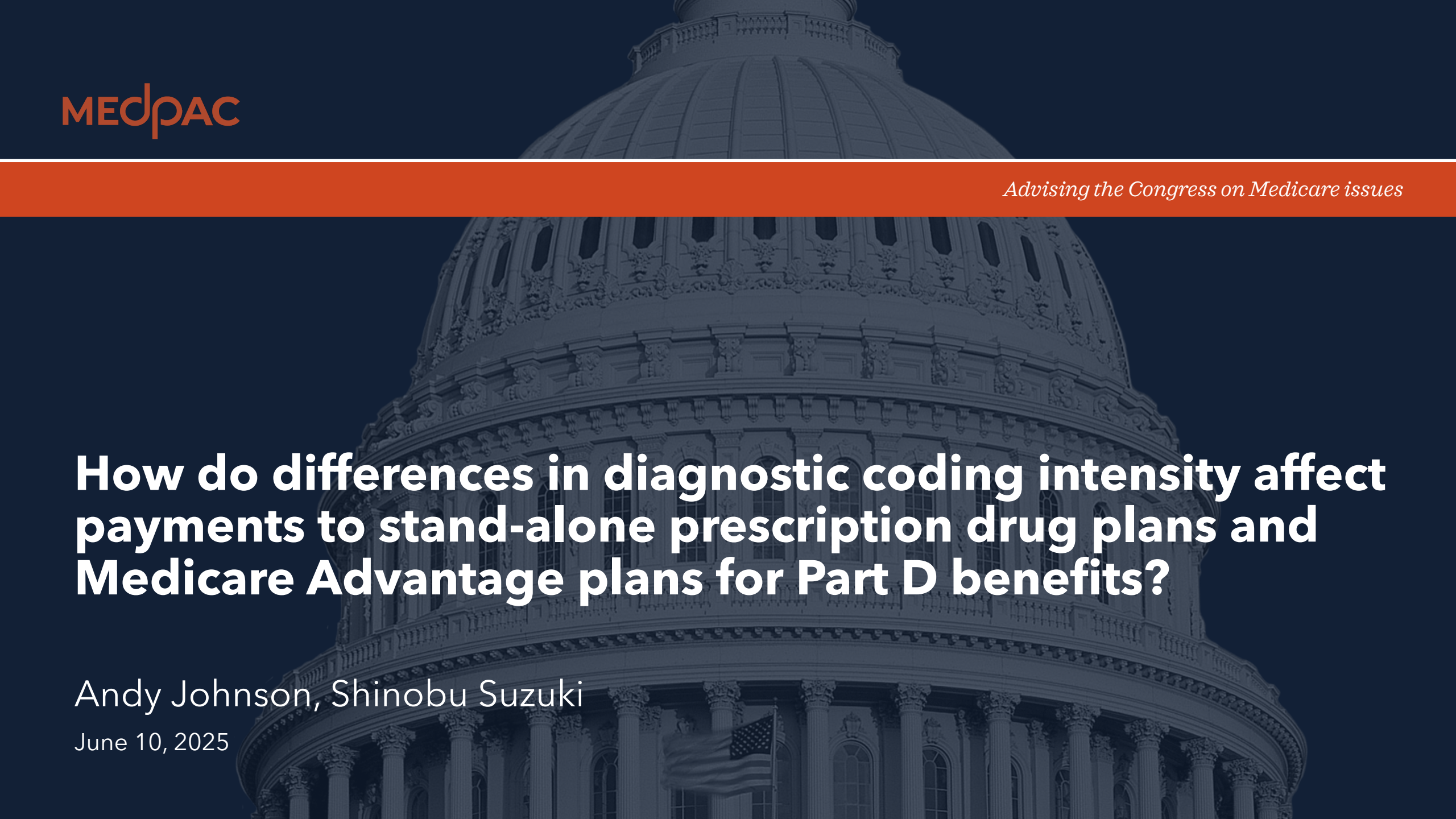
Advising the Congress on Medicare issues



How do differences in diagnostic coding intensity affect payments to stand-alone prescription drug plans and Medicare Advantage plans for Part D benefits?

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MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by the Comptroller General of the Government Accountability Office (GAO) for experience and subject matter expertise
  - Include providers, payers, researchers, beneficiary-focused individuals
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields
- Seven public meetings during the year
  - Staff present analyses informed by site visits, focus groups with beneficiaries and providers, expert panels, input from stakeholders, quantitative analyses
- Guiding principles strive to ensure that beneficiaries have access to high-quality care, providers have incentives to supply appropriate and equitable care in an efficient manner, and that the program's financial burden on taxpayers and beneficiaries is not greater than necessary

Transparency in MedPAC's work

- Commission meetings are open to the public and webcast
- Full meeting transcript publicly available on MedPAC's website
- Presentations are available through webcast and MedPAC's website
- Public comments are disseminated to commissioners and available on MedPAC's website
- Other publications on MedPAC's website include reports, comment letters, testimony, press releases, data books, payment basics, contractor reports, and recommendations
- Publish analytic agenda for the upcoming year

Why coding intensity matters

- Coding intensity occurs when diagnoses are documented at higher rates for enrollees in certain plans
  - Affects payments to Medicare Advantage (MA) and Part D plans through risk adjustment
- Increases payments to MA plans above what Medicare would have paid for the same beneficiaries through traditional FFS Medicare[1]
  - In 2025, Medicare will pay MA plans $40 billion due to coding intensity
- In Part D, increases payments to plans with higher coding intensity and decrease payments to other plans, does not affect overall payments
  - First analysis of the effects of coding intensity on Part D
  - On average, increases payments to MA-PDs and decreases payments to PDPs

Note: MA (Medicare Advantage), FFS (fee for service), MA-PD (Medicare Advantage prescription drug plan), PDP (standalone prescription drug plan).

Source: [1] Medicare Payment Advisory Commission. March 2025. *Report to the Congress: Medicare payment policy*. Chapter 11: The Medicare Advantage program: status report. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf

What is coding intensity and where does it come from?

Payments to MA and Part D plans are risk adjusted

- The MA program (Part C) allows Medicare beneficiaries to receive medical benefits from private plans rather than the traditional FFS program
  - Medicare's payments to MA plans are capitated and adjusted by the CMS-HCC risk model
- Most MA plans include Part D coverage through an MA prescription drug plan (MA-PD); beneficiaries in FFS Medicare can enroll in a standalone prescription drug plan (PDP)
  - A portion of payments to Part D plans is capitated and adjusted by the RxHCC risk model
  - The risk-adjusted share has been about 30 percent in recent years, but will increase to about 80 percent in 2025 (estimated from plans' bids) due to the IRA

Note: MA (Medicare Advantage), FFS (fee for service), CMS-HCC (CMS hierarchical condition category), MA-PD (Medicare Advantage prescription drug [plan]), PDP (standalone prescription drug plan), RxHCC (prescription drug hierarchical condition category), IRA (Inflation Reduction Act of 2022).

* MA plans that do not include Part D coverage are called "MA only" plans.

MA and Part D risk models rely on diagnosis codes

- Risk scores are a beneficiary-specific index of predicted spending relative to average spending (a 1.0 risk score)
  - Risk scores increase (>1.0 score) or decrease (<1.0 score) payment rates based on a beneficiary's expected spending
  - Risk scores based on demographic characteristics and diagnoses
- Link between diagnostic coding in MA and in Part D
  - Diagnoses for both RxHCC and CMS-HCC models come from *physician and hospital records in MA encounter and FFS claims data*
  - Overlap in diagnosis codes used in MA and Part D risk models: *82 percent of RxHCC diagnoses are included in the CMS-HCC model*

Note: MA (Medicare Advantage), RxHCC (prescription drug hierarchical condition category), CMS-HCC (CMS hierarchical condition category), FFS (fee-for-service).

Stronger incentives to report diagnosis codes for MA (MA–PDs) vs. FFS Medicare (PDPs) patients

- FFS (PDPs): Little incentive to code diagnoses
  - Most diagnoses used in risk adjustment from physician and outpatient visits, where there is little incentive to report additional diagnoses
  - PDPs have limited tools to transmit coding incentives to providers
- MA (MA–PDs): Financial incentive to code more diagnoses
  - Tools that are not / less often used in FFS: health risk assessments, chart reviews, pay-for coding programs, capitated payments or vertical integration
  - MA plans have a contractual relationship with physicians and hospitals
- Differences in diagnostic coding can be due to more comprehensive coding, diagnostic discretion, fraud, other reasons
  - Coding differences affect payment, no matter the reason

Note: MA-PD (MA prescription drug plan), PDP (standalone prescription drug plan), FFS (fee-for-service), MA (Medicare Advantage).

Coding intensity in Medicare Advantage

Estimating MA coding intensity

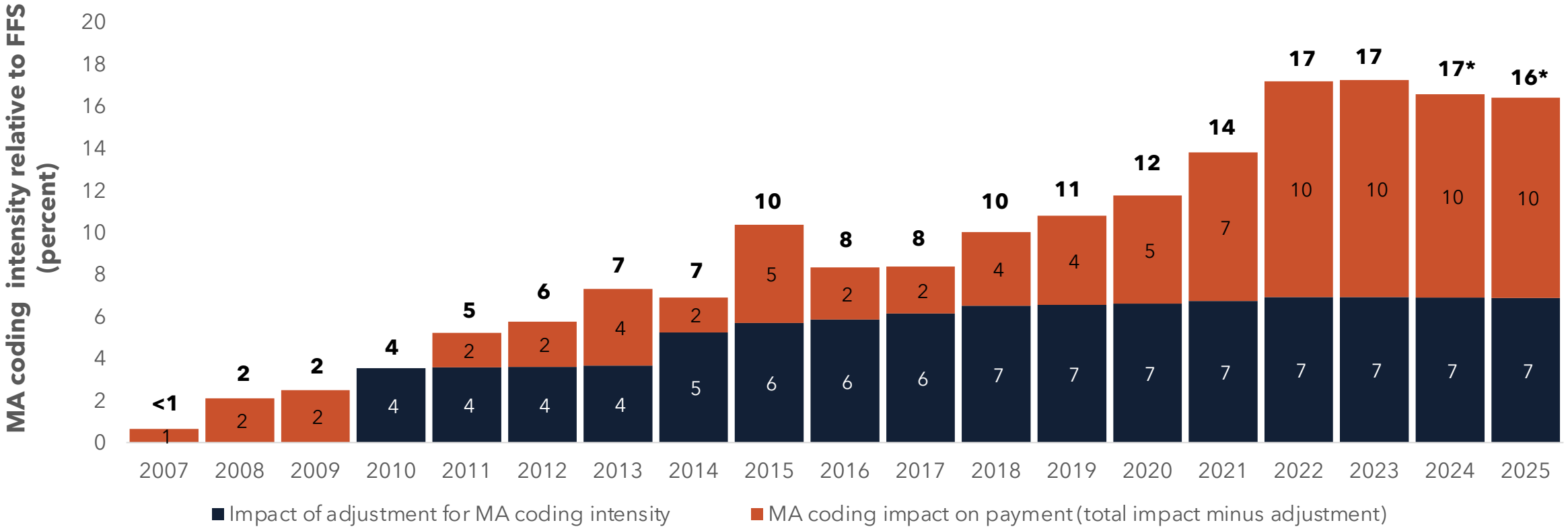
- The CMS-HCC model is estimated on FFS data
- MedPAC uses the DECI method developed by Kronick and Chua[1] and modified[2]
  - To account for Medicaid eligibility and institutional status
  - To constrain new enrollees to have no coding intensity (risk scores not based on diagnoses)

$$\textbf{DECI estimate} = \frac{\dfrac{\text{National average MA CMS-HCC risk score}}{\text{National average FFS CMS-HCC risk score}}}{\dfrac{\text{National average MA demographic only risk score}}{\text{National average FFS demographic only risk score}}}$$

Note: MA (Medicare Advantage), CMS-HCC (CMS hierarchical condition category), FFS (fee-for-service), DECI (demographic estimate of coding-intensity).
* MedPAC's method excludes beneficiaries with end-stage renal disease and beneficiaries residing in Puerto Rico.

Source: [1] Kronick, R., and F.M. Chua. 2021. Industry-wide and sponsor-specific estimates of Medicare Advantage coding intensity. November 11. Available at https://ssrn.com/abstract=3959446. Kronick, R., and F.M. Chua. 2025. Are fewer diagnoses better? Assessing a proposal to improve the Medicare Advantage payment system. *Health Affairs* 44, no. 1 (January): 66-74.
[2] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare payment policy, Appendix 11-B*. Washington, DC: MedPAC.

MedPAC's estimates of MA coding intensity

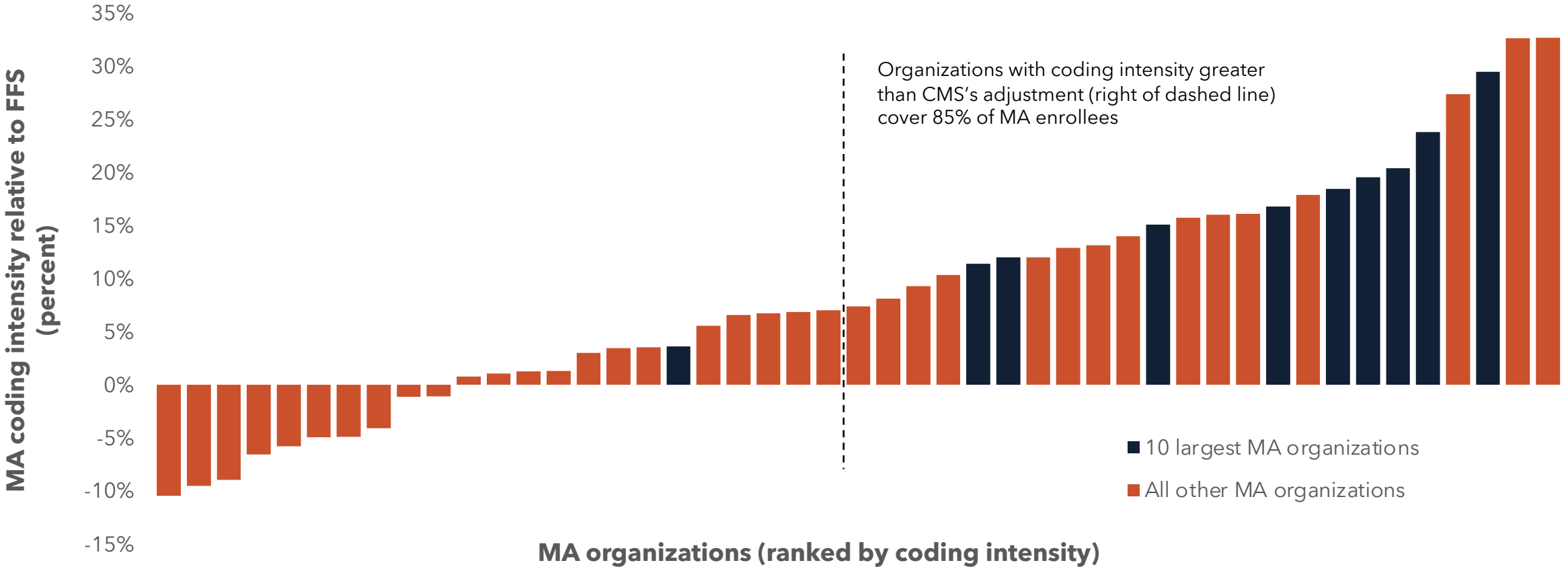


Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates account for differences between MA and FFS populations in age, sex, Medicaid eligibility, and institutional status. New enrollees are constrained to have no coding intensity.

*For 2024 and 2025, we projected coding intensity based on the annual trend from 2019 through 2023 and then reduced that trend to account for the phase-in of the V28 risk adjustment model.

Source: MedPAC analysis of CMS enrollment and risk score files.

Coding intensity generates payment differences across MA organizations



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates are for 2023 and account for any differences between MA and FFS populations in age, sex, Medicaid eligibility, and institutional status. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 50,000 enrollees.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Many studies find generally consistent results about coding intensity in MA

Curto, V. E., E. Politzer, et al. 2025. Coding intensity variation in Medicare Advantage. *Health Affairs Scholar* 3, no. 1 (Jan).

Kronick, R., F. M. Chua, et al. 2025. Are fewer diagnoses better? Assessing a proposal to improve the MA payment system. *Health Affairs* 44, no. 1 (Jan): 66–74.

Jacobs, P. D. and T. J. Layton. 2025. Identifying coding intensity in Medicare Advantage through switchers. *Health Services Research* e14628 (Apr).

James, H. O., B. A. Dana, et al. 2024. MA health risk assessments contribute up to $12 billion per year to risk-adjusted payments. *Health Affairs* 43, no. 5 (May): 614–622.

Jacobs, P. D. 2024. In-home health risk assessments and chart reviews contribute to coding intensity in MA. *Health Affairs* 43, no. 7 (July): 942–949.

Meyers, D. J. and A. N. Trivedi. 2021. Medicare Advantage chart reviews are associated with billions in additional payments for some plans. *Medical Care* 59, no. 2 (Feb): 96-100.

Geruso, M. and T. Layton. 2020. Upcoding: Evidence from Medicare on squishy risk adjustment. *Journal of Political Economy* 12, no. 3 (Mar): 984–1026.

Hayford T. B. and A. L. Burns. 2018. MA enrollment and beneficiary risk scores: Difference-in-differences analyses show increases for all enrollees on account of market-wide changes. *Inquiry* 55 (Jan–Dec): 46958018788640.

Jacobs P. D. and R. Kronick. 2018. Getting what we pay for: How do risk-based payments to MA plans compare with alternative measures of beneficiary health risk? *Health Services Research* 53, no. 6 (Dec): 4997–5015.

Kronick, R. and W. P. Welch. 2014. Measuring coding intensity in the Medicare Advantage program. *Medicare & Medicaid Research Review* 4, no. 2.

Government Accountability Office. 2013. *Medicare Advantage: Substantial excess payments underscore need for CMS to improve accuracy of risk score adjustments*. GAO–13–206. Washington, DC: GAO.

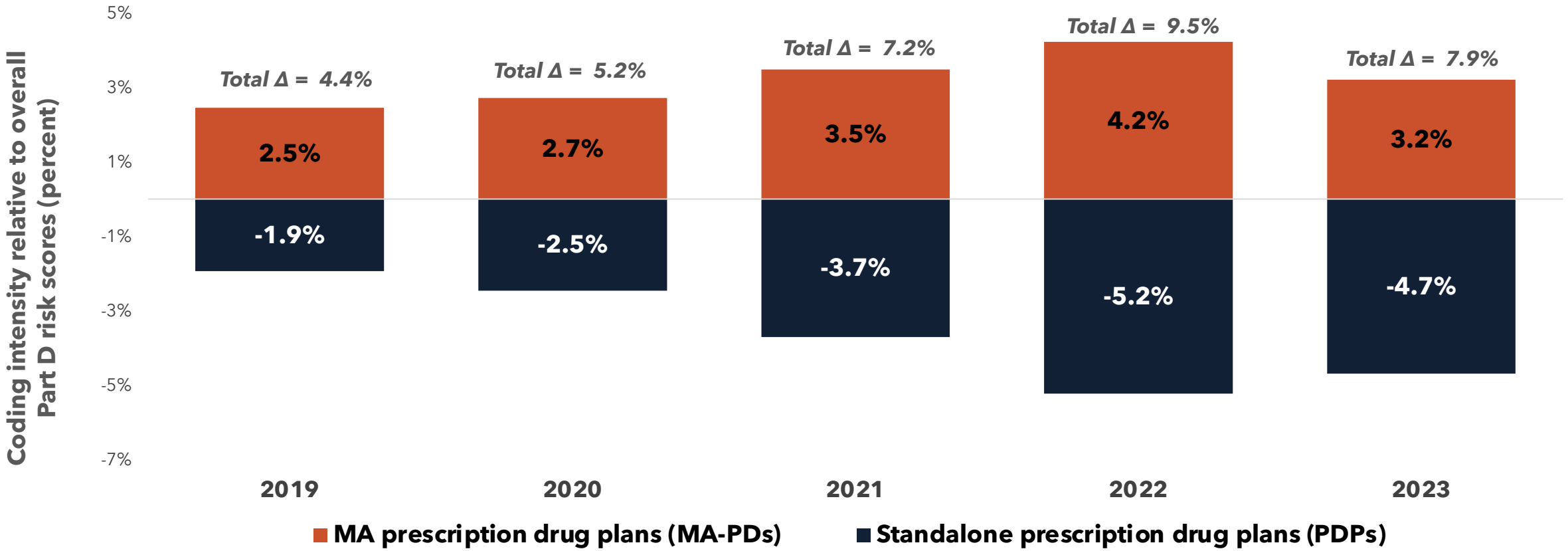
Coding intensity in Medicare Part D

Estimating coding intensity in Part D

- The RxHCC model is estimated using all Part D enrollees
  - Coding differences do not affect overall Part D spending but can generate different payments and premiums across plans for similar enrollees
- We adapted MedPAC's DECI method for Part D by:
  - Estimating coding intensity separately for MA–PDs and PDPs relative to the entire Part D population
  - Addressing differences in the share of enrollees in Part D risk-model segments for LIS, non-LIS, and institutionalized beneficiaries
  - Estimating demographic risk scores using gross Part D–plan liability
- MedPAC DECI method works well in MA, first application to Part D

Note: RxHCC (prescription drug hierarchical condition category), DECI (demographic estimate of coding intensity), MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (standalone prescription drug plan), LIS (low-income subsidy), MA (Medicare Advantage).

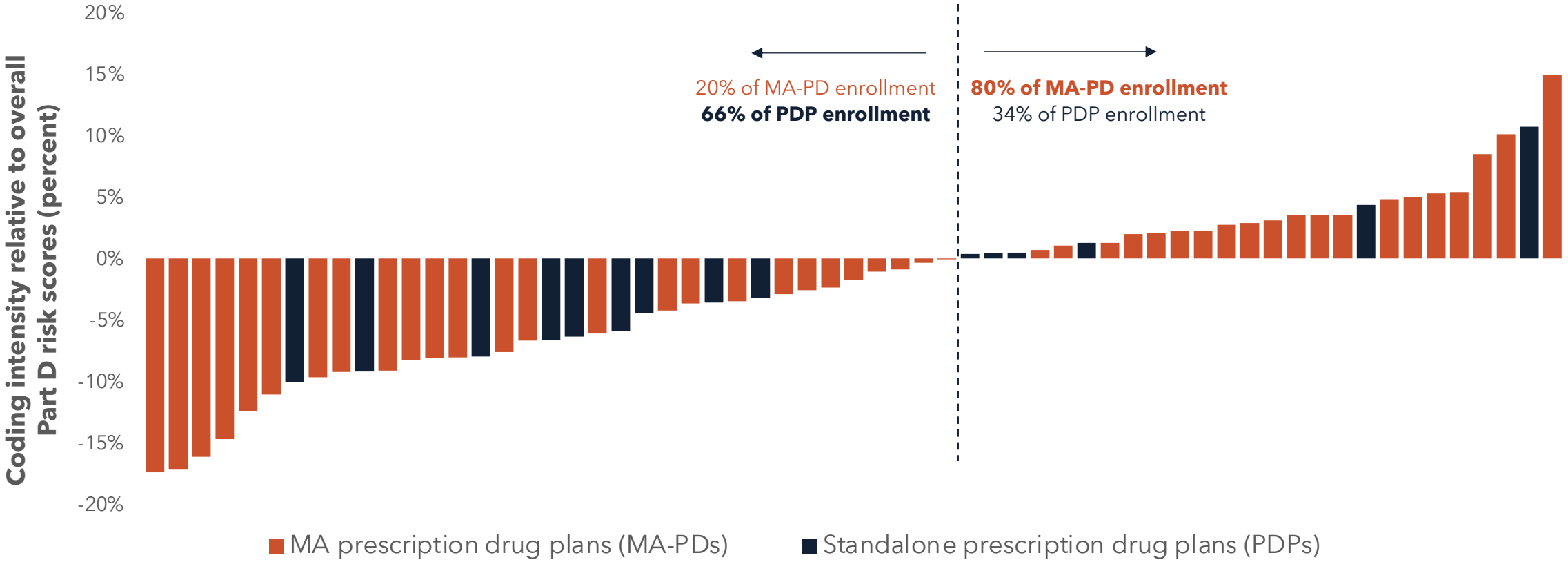
Estimated coding intensity increased Part D risk scores for MA–PDs and decreased scores for PDPs, on average, 2019–2023



Note: MA–PD (Medicare Advantage–prescription drug [plan]), PDP (standalone prescription drug plan). All estimates account for any differences in age, sex, low-income subsidy eligibility, and institutional status between MA-PD and PDP enrollees. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Coding intensity generated payment differences across MA-PD and PDP organizations, 2023



Note: MA–PD (Medicare Advantage–prescription drug [plan]), PDP (standalone prescription drug plan). All estimates account for any differences in age, sex, low-income subsidy eligibility, and institutional status between MA-PD and PDP enrollees. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding. Figure excludes beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan, and for each MA-PD or PDP market, the figure excludes organizations with fewer than 50,000 enrollees in the respective market.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Conclusion

- Differing coding incentives led to higher MA-PD and lower PDP risk scores, on average, between 2019 - 2023
  - Starting in 2025, separate normalization factors for MA–PD and PDP risk scores is likely to address these *average* differences
- Large variation in coding intensity across parent organizations for MA-PD and PDP populations
- Future research questions:
  - Do other methods of estimating Part D coding intensity yield similar results?
  - Why is estimated effect of coding intensity larger for MA than for Part D risk scores?
  - Are HCCs/diagnoses with largest coding differences in MA, Part D, or both models?
  - Is MA and Part D coding intensity correlated within parent organizations?

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